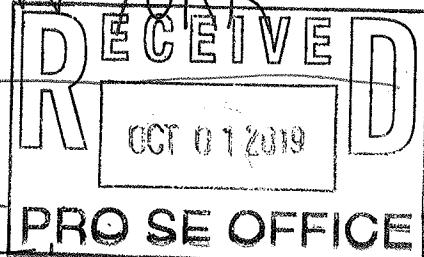


Case 1:19-cv-01447-JV Document 2 Filed 09/30/19 Page 1 of 7
UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

CIVIL COVER SHEET



1. (a) Plaintiff(s) : Robert W. Johnson
(b) Bronx County
(c) 3345 Fish Ave. : APT. 1 : Bronx, NY 10469

19 CV 9127

Defendants: Spadafora & Verrastro LLP;
Verrastro James P., James P. Verrastro,
Joseph C. Todoro, Joseph Anthony Todoro,
God Apartments Belmont Management,
Belmont Management Company Inc.,
God City Housing, Belmont Development,
Belmont Construction, Ryan Hudspeth
& Social Security Administration.

2. Basis of Jurisdiction : 28 U.S.C
§ 1331: Federal Question.

A. Basis For Federal Jurisdiction:

Ineffective Counsel, Breach of Contracts, Discrimination, Due Process Violations, Civil Rights Violations, Abuse of Authority, Denial of Plaintiff's Civil Rights & Disabilities & U.S. Constitutional Violations.

3. Statement of Claim:

Spadafora & Verrastro LLP: Verrastro James P. failed to represent Plaintiff in 01/06/14 God City Housing bicycle accident due to Belmont Housing Development failure to keep facility protected from civilians being injured due to bad weather conditions. God City Housing failed to accept responsibility for Plaintiff's injuries that have worsened since 01/06/14. Social Security Administration failed to grant Plaintiff benefits due to SSA assumptions.

Related Cases: Second Circuit Courts
Case 1:19-cv-01447-LJV Document 2 Filed 09/30/19 Page 3 of 7
Docket "18-2399".

Origin: Original Proceeding.

Jury Demand: Yes.

Basis of Jurisdiction For Jury Demand is
28 U.S.C § 1331: Federal Question.

Nature of Suit: Civil Rights 440: Other
Civil Rights.

Relief Sought: \$550 Trillion For Punitive
Damages & \$400 Billion For Future Punitive
Damages; Judicial Sanctions; All Other
Actions Deemed Just & Proper; 100%
Ownership of Defendants Corporations.

September 20, 2019

Robert W. Johnson
Robert W. Johnson
3345 Fish Ave. APT. 1
Bronx, NY 10469

EMERGENCY SERVICE FACESHEET (Page 1 of 2)

Erie County Medical Center Corp.

EXHIBIT NO. B22F

PAGE 2 OF 4

NAME JOHNSON,ROBERT		REGISTRATION NUMBER V00008887890		MEDICAL RECORD NUMBER M000810238		
SOCIAL SECURITY NO. 076-78-9808	INS. PLAN HARTWC	ARRIVAL TIME 01/06/14 0957	TRIAGE BY CHARRING	TRIAGE TIME 01/06/14 1013	REFERRED TIME	
PRIMARY CARE PROVIDER PHONE		ABS SVC 02/26/1884	DR TYPE 29	BIRTHDATE M	AGE 3	ACUTITY WR -
CHIEF COMPLAINT Neck Pain		ALLERGIES No Known Allerg	EMERGENCY ATTENDING			

MEDICAL CONDITIONS **DENIES**MEDICATIONS **DENIES**

TIME SEEN 12:10 1/6/14	TRIAGE NURSE ASSESSMENT PT S/P FALL OFF BIKE -LOC.C.O NECK, BACK AND PELVIC PAIN. AMBULATING WITH STEADY GAIT.	Hx/PFSH limited due to: <input type="checkbox"/> Mental Status <input type="checkbox"/> Critical Illness <input type="checkbox"/> Nonverbal (Peds) Other:
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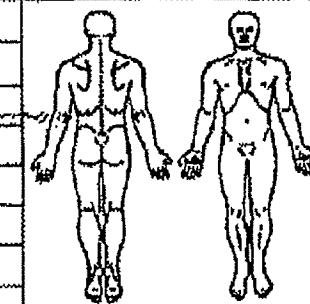
Additional history from: Old records Family EMS Transfer/NH

HISTORY (Location, quality, severity, duration, timing, context, modifying factors, assoc. signs and symptoms) <i>2yr Hx of neck pain off & on 2-3 times per year, now 6 back pain - constant pain, sharp, sharp, and radiating. Report of chronic back pain for full last year, but not consistent from 1-2 days to 1-2 weeks. pain less in fall, full time in winter in spring & summer</i>	LAST VISITS
---	-------------

(D, D, O, I, 2)		
PHYSI	FAM HX	SOC. HX
<i>chronic pain</i>		

MAR ST	M	S	D
TOB	<input checked="" type="checkbox"/>	<input type="checkbox"/>	H/O
ETOH/SUB	<input checked="" type="checkbox"/>	<input type="checkbox"/>	H/O
NH	<input checked="" type="checkbox"/>	<input type="checkbox"/>	H/O

PHYSICAL	TEMP 97.6	B/P 127/73	PULSE 67	RESP 16	PULSOX 100	PAIN LOCATION NECK, BACK	PAIN SEVERITY 10
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<i>Gen: norm, abd Heart: reg, perf, norm, ECG: norm, Lungs: norm, CV: norm Lungs: clear, abd: norm, ECG: norm, Lungs: norm, CV: norm Abd: norm, ECG: norm, Lungs: norm, CV: norm Neuro: norm, Lungs: norm, CV: norm</i>	PATIENT Fecal occult results: POS / NEG Pos. Control: +/- Neg. Control: +/-
DIAGNOSTIC TESTS	

Spine x-ray: neg, no fracture CHART COMPLETEPT SEEN & DISCUSSED WITH ATTEND/EXT-HPI
RN ROS / PFSH/DX / RX REVIEWED / AGREE

DIAGNOSIS <i>Neck sprain</i>	ADMITTING SERVICE :	CONSULTATION / PRIMARY PHYSICIAN
	TIME NOTIFIED :	TIME CALLED / RESPONDED
	ATTENDING :	

PHYSICIAN/EXT SIGNATURE <i>[Signature]</i>	DATETIME <i>1/6/14</i>	ED ATTENDING <i>R. G. M. S. C. MD</i>	DATETIME <i>1/6/14</i>
Rev. 10/13	M000810238	1/6/14	V00008887890
ED.001			

Erie County Medical Center Corp.

NAME JOHNSON,ROBERT		REGISTRATION NUMBER V00093887890		MEDICAL RECORD NUMBER M000810230	
SOCIAL SECURITY NO. 078-78-9909	INS. PLAN HARTWC	ARRIVAL TIME 01/06/14 0957	TRIAGE BY CHARRING	TRIAGE TIME 01/06/14 1013	REFERRAL TIME
PRIMARY CARE PROVIDER	TELEPHONE	BIRTHDATE 02/26/1984	AGE 29	SEX M	ACUITY 3
CHIEF COMPLAINT Neck Pain	ALLERGIES	No Known Allerg			

LAST ER VISIT: 12/29/12 ARRIVAL MODE: Self EMS AGENCY/UNIT: TRAVEL LAST 2 Wk: N WHERE TO: N
 LAST ADMIT DATE: LAST DISCHARGE DATE: ADMIT PHYSICIAN: ADMIT SERVICE: N
 HIV CONSENT: TRIAGED: V00093887890A

DNR ORDER: N FORM WITH PATIENT: N BILL OF RIGHTS GIVEN TO PATIENT/FAMILY: N TRANSFER IN: N TRANSFER FROM: N HOSPICE: N
 LIMITATION OF TREATMENT: N RECEIVED HIPAA NOTICE OF PRIVACY PRACTICES: Y HEALTH CARE PROXY: N HEALTH CARE PROXY AGENT: N

PROCEDURE NOTES	Reason:	TIME	RE-EVALUATION	Critical Care
<input type="checkbox"/> Conscious sedation	<input type="checkbox"/> RSI Intubation			30-74 mins 75-104 mins 105-134 mins 135-164 mins 165-194 mins
<input type="checkbox"/> personally supervised the procedures as noted above.				

ATTENDING NOTE

do neck and LBP s/p fall off ch bicycle
NO Hx NO Mtx to ch bicycle

pmpt: back p.

CONST	<input type="checkbox"/> Rev -Mesa of at least 3/s signs: <input type="checkbox"/> NL -Gen appearance of patient	GU	<input type="checkbox"/> NL -Ex. genit/vag <input type="checkbox"/> NL -Urethra <input type="checkbox"/> NL -Bladder <input type="checkbox"/> NL -Cervix <input type="checkbox"/> NL -Uterus <input type="checkbox"/> NL -Adnexa/parametria	SOC. HX	MAR ST	M S D
EYES	<input checked="" type="checkbox"/> NL -Insp conj/lids <input checked="" type="checkbox"/> NL -Exam pupils/iris/ea <input type="checkbox"/> NL -Ophthalmoscopio exam			TOB	Y	HO
ENT	<input type="checkbox"/> NL -Ext insp ears/nose <input type="checkbox"/> NL -Otoscopio exam <input type="checkbox"/> NL -Assess hearing <input type="checkbox"/> NL -Nasal mucosa/septum/turb <input type="checkbox"/> NL -Lips/teeth/gums <input type="checkbox"/> NL -Exam oropharynx	Lymph	<input type="checkbox"/> NL -Palp of nodes in 2+ areas: <input type="checkbox"/> NL -Neck <input type="checkbox"/> NL -Axillae <input type="checkbox"/> NL -Groin <input type="checkbox"/> NL -Other	ETOH/SUB	Y	HO
Neck	<input type="checkbox"/> NL -Exam neck <input type="checkbox"/> NL -Exam thyroid	Muscl/ skel	<input checked="" type="checkbox"/> NL -Exam gait/station <input type="checkbox"/> NL -Exam joints/bones/muscles: <input checked="" type="checkbox"/> NL -Insp and/or palp <input type="checkbox"/> NL -Range of motion <input type="checkbox"/> NL -Stability <input type="checkbox"/> NL -Muscle strength/tonus <input type="checkbox"/> NL -Back <input type="checkbox"/> NL -Pelvis			
Resp	<input checked="" type="checkbox"/> NL -Resp effort <input type="checkbox"/> NL -Percus chest <input checked="" type="checkbox"/> NL -Palp chest <input checked="" type="checkbox"/> NL -Aus lungs	Skin	<input type="checkbox"/> NL -Insp skin/subQ tissue <input type="checkbox"/> NL -Palp skin/subQ tissue			
CV	<input type="checkbox"/> NL -Palp heart <input type="checkbox"/> NL -Aus heart	Neuro	<input type="checkbox"/> NL -Test CN nerves <input checked="" type="checkbox"/> NL -DTR's <input type="checkbox"/> NL -Sensation			
	Exam of: <input type="checkbox"/> NL -carotid art <input type="checkbox"/> NL -abd aorta <input type="checkbox"/> NL -feml art <input type="checkbox"/> NL -pedal pulses <input type="checkbox"/> NL -extrem - edema/varicosities	Psych	<input type="checkbox"/> NL -Desc judgment/insight <input type="checkbox"/> NL -Brief assess MS: <input checked="" type="checkbox"/> NL -Orient to time/place/person <input checked="" type="checkbox"/> NL -Recent/remote memory <input type="checkbox"/> NL -Mood/affect			
Chest (Breasts)	<input type="checkbox"/> NL -Insp breasts <input checked="" type="checkbox"/> NL -Palp breasts/axillae					
GI (Abd)	<input type="checkbox"/> NL -Abd-masses/tender <input type="checkbox"/> NL -Liver/spleen <input type="checkbox"/> NL -Hemla <input type="checkbox"/> NL -Rectum <input type="checkbox"/> NL -Stool occult blood					
GU	<input type="checkbox"/> NL -Scrotal contents <input type="checkbox"/> NL -Penis <input type="checkbox"/> NL -Prostate					

Rev. 10/13

EO.002

RELEASED 1/6/14

SIGNATURE

DATE / TIME

PT SEEN & DISCUSSED WITH RESIDENT / EXT-HPI
AN R08 / PFSH / DX / RX REVIEWED / AGREED

M00093887890

Y00093887890

EMERGENCY DEPARTMENT - DISCHARGE INSTRUCTIONS

E.C.M.C. NO. B22F
ESSEX COUNTY MEDICAL CENTER
CORPORATION
PAGE 4 OF 4

Name: **JOHNSON, ROBERT**Med. Rec. #: **M000810238** Date of Birth: **02/26/1984** Age: **29**Visit #: **V00003887890** Insurance: **HARTFORD-COMPENSATION**Service Date: **01/06/14** Service Time: **0957** Room:

Check with your primary provider or prescribing specialist for regular medication dosages and continued appropriateness of medications.

 Please give a copy of this information to your primary care provider

Take medications only as prescribed: Take following medicine(s) in addition to your regular medicine(s).
 Take following medicine(s) and make changes to your present medicine(s) as noted below.

Prescription Monitoring Program reviewed: Yes No (Exempt: Emergency Department; quantity does not exceed 5 day supply)

NO.	MEDICINE	INSTRUCTIONS
MED. #1	<i>None</i>	
MED. #2		
MED. #3		

Restrictions:

None Return Date 1/1 No job modification necessary
 Modified Activity Start Date 1/1 End Date 1/1 Modified duty described below:
 Off Work/School Start Date 1/1 End Date 1/1

Modify Activity As Follows

Do Not operate moving machinery/motor vehicles/bicycles
 Do Not work above ground level (climbing ladders, elevated platforms, catwalks, etc.)
 No Pushing/Pulling/Lifting with arm/shoulder Right Left
 No Flexion/Extension of elbow Right Left
 Limited Lifting/Carrying, not to exceed 10 lbs. 25 lbs. 50 lbs
 No Bending/Twisting at Waist Neck
 Must have a sit down job
 No Squatting/Kneeling

Additional Instructions:*as directed***Follow up Physician:** Follow up only if not feeling better in _____ days**Phone Number:** Must follow up within _____ days**Return to ER if you have the following symptoms:****IF YOU HAVE ANY QUESTIONS ABOUT YOUR CULTURE RESULTS CALL 716-961-7723 AFTER 48 HOURS***None***Physician/Nursing Personnel Signature**

I understand treatment and instructions given to me.

Robert W. Johnson
Patient Signature

Date

Time

*1-14-14**1350* TRANSPORTATION APPROPRIATE FOR CONDITION

- You have received emergency treatment at E.C.M.C. Follow the instructions carefully. If your condition continues to deteriorate, or unexpected symptoms develop, call the follow-up physician for advice or return to the Emergency Department for re-evaluation. Otherwise follow up as instructed. Call the doctor's office the next day for an appointment.
- If X-rays were taken, they were interpreted by an Emergency Physician while you were being treated in the E.D. These tests will be reviewed again by appropriate specialists the next day. You will be notified immediately in case of additional findings.

0622636
Rev. 10/13

RHM:BS:002



M000810238



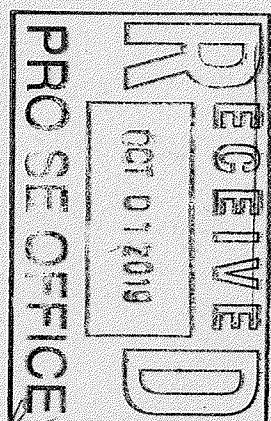
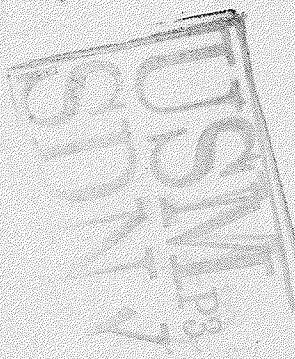
V00003887890



ROBERT W. JOHNSON
3345 FISH AVE.
APT. 1
BRONX, NY 10007



U.S. POSTAGE PAID
FCW LG ENV
BRONX, NY
SEP 28 19
AMOUNT
\$1.15
R2305K135207-12



RECEIVED
2019 SEP 30 PM 4:23
CLERK'S OFFICE
S.D.N.Y.
COURT CLERK
U.S. COURTHOUSE
500 PEARL ST.
NEW YORK, NY 10007